Psychotherapy Associates of Tampa Bay L.L.C.

Patient Authorization for the Use and Disclosure of Protected Health Information

By signing this form, I authorize Psychotherapy Associates of Tampa Bay, L.L.C. to use and/or disclose certain protected health information (PHI) about me to (name, address, and telephone number):

_____

_____

_____

This authorization permits Psychotherapy Associates of Tampa Bay, L.L.C. to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

_____

_____

_____

The information will be used or disclosed for the following purpose(s):

_____

_____

_____

This authorization will expire on or before _____

I am not required to sign this authorization in order to receive treatment from Psychotherapy Associates of Tampa Bay, L.L.C. and understand that I have the right to refuse signing this form. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Psychotherapy Associates of Tampa Bay, L.L.C.
BayCare Outpatient Center
12780 Race Track Road, Suite 411
Tampa, FL 33626

_____ _____
Signature of Patient or Parent/Legal Guardian Date

_____ _____
Signature of Witness Date

☐ I have been provided with a copy of this form for my records.
☐ I do not wish to receive a copy of this form for my records.